FREDERICK COUNTY MENTAL HEALTH SERVICES

REFERRAL DATE _____ THERAPIST/PSYCHIATRIST _____ ADMISSION DATE _____

NAME _____ MAIDEN NAME _____ MARITAL STATUS Single

ADDRESS _____

HOME PHONE _____ WORK PHONE _____ DATE OF BIRTH _____ AGE _____ SEX _____

SOCIAL SECURITY NUMBER	MEDICAL ASSISTANCE NUMBER	INSURANCE CARRIER/NUMBER/TYPE

FEE _____ RESPONSIBLE PARTY SSN# _____

RESPONSIBLE PARTY NAME _____

HOUSEHOLD COMPOSITION

NAME	DOB	RELATION	EDU	OCCUPATION	INCOME

FAMILY PHYSICIAN _____

REFERRED BY _____ (REASON ON BACK)

PREVIOUS CARE _____

DIAGNOSES Axis I _____ DSM CODE _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

CLOSING INFORMATION _____ DATE: _____

AGENCY _____ TYPE OF SERVICE _____

REASON FOR DISCHARGE _____

NUMBER OF VISITS _____ DATE OPENED _____ DATE CLOSED _____ FINAL DIAGNOSIS _____

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